U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 January 2004

CASE NO.: 1995-BLA-01469

In the Matter of:

RAY CASE,
Claimant,

v.

L.H. HALL COAL COMPANY,
Employer,

and

OLD REPUBLIC INSURANCE COMPANY,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Appalachian Citizens Law Center, Inc.,
For Claimant,
Stephen A. Sanders, Esquire,
On the brief

Greenberg Traurig, LLP,
For Respondent,
Laura Metcoff Klaus, Esquire,
On the brief

Before: JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS
UPON REMAND FROM THE BENEFITS REVIEW BOARD

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act" or "the BLBA") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On September 27, 2002, this case was remanded to the Office of Administrative Law Judges from the Benefits Review Board. Subsequently, the case was assigned to me. This decision is based upon an analysis of the record, the arguments of the parties, and the applicable law.

ISSUES

It was determined that Claimant engaged in coal mine employment ("CME") for a period of 12 years and 4.5 months. This determination was not contested by the parties and I find that the record substantiates the finding. The following issues remain for adjudication on remand:

(1) whether Claimant's subsequent claim was timely filed;
(2) whether Claimant has pneumoconiosis;
(3) whether his pneumoconiosis arose out of his CME;
(4) whether he is totally disabled;
(5) whether his total disability is due to pneumoconiosis; and
(6) whether he has established a material change in conditions pursuant to 20 C.F.R. section 725.309(d).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Ray Case ("Claimant" herein) filed his first claim for benefits on December 28, 1979. DX-42. The District Director ("the Director") ultimately denied the claim on October 1, 1981. DX-42. Claimant took no further action on his first claim.

Claimant filed his second claim on September 18, 1986. DX-1 The Director denied the claim on February 26, 1987, July 23, 1987, and October 6, 1987. DX 14; 38; 40. Claimant requested a hearing before the Office of Administrative Law Judges ("OALJ"), and his request was referred for hearing on January 7, 1988. DX-16; 44. Pursuant to the holding by the Benefits Review Board ("the Board") in *Lukman v. Director, OWCP*, 10 BLR 1-71 (1988), on October

[1] Unless indicated otherwise, all applicable regulations which are cited in this Decision and Order are included in Title 20, Code of Federal Regulations, and are cited by part or section only.

24, 1988, the case was remanded to the Director for further processing and to allow Claimant to appeal the Director's denial directly to the Board. DX-53. Following processing of the case, on April 14, 1994, Director awarded benefits commencing September, 1993. DX-63. L.H. Hall Coal Co. ("Employer") requested a hearing before OALJ and on May 27, 1994, the case was referred for hearing. DX-64; 66. Subsequently, the Employer moved for clarification regarding the designated responsible operator, and accordingly, on October 24, 1988, Administrative Law Judge ("ALJ") Daniel L. Leland remanded the case to the Director. DX-67.

On August 22, 1994, Director initiated payments to Claimant by the Black Lung Disability Trust Fund, retroactive to August 1, 1994, offset by Claimant's monthly state workers' compensation benefits. Subsequently, Employer conceded that it is the responsible operator, and on April 24, 1995, the case was referred to OALJ for a hearing. DX-67; 68. The case was assigned to ALJ Paul H. Teitler, who held a hearing on January 23, 1996 in Prestonsburg, Kentucky. On September 9, 1996, ALJ Teitler issued a Decision and Order Awarding Benefits to Claimant. Employer appealed that determination to the Board.

On November 25, 1997, the Board issued a Decision and Order vacating the award and remanding the case for further consideration. After permitting the Employer to submit additional evidence in compliance with the Board's remand Order, on March 4, 1999, ALJ Teitler issued a Decision and Order on Remand Awarding Benefits.

Employer appealed to the Board, which on September 27, 2000, issued a second Decision and Order vacating the award and remanding the case for further consideration. On May 17, 2001, ALJ Teitler issued a second Decision and Order Awarding Benefits on Remand. Employer again appealed that determination to the Board.

In its Decision and Order of September 27, 2002, the Board vacated the ALJ's decision and remanded the case. On remand, the Board ordered consideration of whether Claimant's subsequent claim is barred as untimely, citing the holding of the Federal Court of Appeals for the Sixth Circuit in *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 22 BLR 2-288 (6th Cir. 2001). The Board also ordered consideration of whether the newly submitted medical evidence established a material change in conditions, pursuant to its Decision and Order of September 27, 2000.[2] Therein, the Board identified six issues to be considered in reaching this determination:

(1) whether the new evidence submitted with the subsequent claim that reflects a diagnosis for pneumoconiosis differs qualitatively from evidence submitted with the previously denied claim;

(2) the impact of legal precedent on the weight to accord medical opinion evidence relevant to the issue of pneumoconiosis;

(3) the discrepancy between the determined length of CME and the length of CME relied upon by physicians in reaching their conclusions regarding the existence of pneumoconiosis, and its effect upon the credibility of the experts;

(4) re-evaluation of Dr. Cohen's opinion in consideration of Claimant's smoking history as compared with the history adopted by the doctor;

[2] The Board in its September 27, 2002 Decision and Order erroneously stated that it had issued its earlier Decision and Order on September 22, 2000.

(5) weighing all the newly submitted evidence, like and unlike;
(6) consider impact of adopted smoking history upon credibility of medical opinions regarding whether Claimant is disabled due to pneumoconiosis.

The Board also directed consideration of the evidence pursuant to the standard set forth in *Flynn v. Grundy Mining Co*., 21 BLR 1-41 (1997).

In its most recent Decision and Order, the Board also ordered that this case be assigned to a different ALJ than ALJ Teitler. By Order issued September 3, 2003, ALJ Teitler assigned this case to me.

B. Factual Background

Claimant was born on April 13, 1940, and has a fourth grade education. DX-1. He married Emma Jarrell on February 3, 1962, and she is his only dependent for purposes of augmentation of benefits under the Act. Tr. at 5-11.

At the hearing, Claimant testified that he left his work with the coal mines in 1979 based on the advice of Dr. Larry Leslie, who has been his treating physician since 1979. TR at 25-28. Claimant stated that he had experienced breathing difficulties that have worsened over time. Id. He coughs frequently, experiences dizzy spells, and has difficulty sleeping at night. TR. at 28. He described sleeping on the couch or upright in a chair. Id. At the time of the hearing, Claimant was no longer hunting, gardening or mowing the lawn. He said that he easily becomes short of breath with walking. TR. at 28. Claimant also complained of constant pain in his shoulders and back. TR. at 28-29. Claimant testified that he smoked one half pack of cigarettes per day for many years. TR. at 32-33. At the time of the hearing, he admitted to smoking between two and four cigarettes a day and chewing tobacco. TR. at 35.

On July 10, 1981, Claimant was awarded Kentucky workers' compensation benefits based on permanent and total disability since December 22, 1979 due to pneumoconiosis and/or silicosis arising out of CME. DX-26.

C. Timeliness of Claim

A claim for benefits under the Act "shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the …Act…, whichever is later." 20 C.F.R. § 725.308(a). 20 C.F.R. § 725.308(c) provides that "[t]here shall be a rebuttable presumption that every claim for benefits is timely filed. However… the time limits in this section are mandatory and may not be waived or tolled except a showing of extraordinary circumstances." 20 C.F.R. § 725.308(c).

In his initial decision on the claim issued on September 9, 1996, ALJ Teitler found that the claim was timely filed. Subsequently, the U.S. Court of Appeals for the 6th Circuit concluded that the three year period to file a claim applies to a subsequent (duplicate) claim, and begins to run the "first time that a miner is told by a physician that he is totally disabled by

pneumoconiosis". *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk],* 264 F. 3d 602, 608 (6th Cir. 2001). The Court distinguished "between premature claims that are unsupported by a medical determination…and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period." Id.

The Court of Appeals elaborated on this issue in a subsequent (unpublished) decision, wherein the Court held that denial of the first claim on grounds that the miner did not establish the presence of pneumoconiosis "necessarily renders any prior medical opinion to the contrary invalid". *Peabody Coal Co. v. Director, OWCP [Dukes]*, 2002 WL 31205502 (6th Cir. Oct. 2, 2002)(unpub.). The Court in *Dukes* rejected as dicta the language in *Kirk* that stated that the statutory period would commence upon communication of a premature prior medical opinion in the miner's favor that did not establish entitlement. Id. The Court stated that it

> agreed[s] with the reasoning of the Tenth Circuit Court of Appeals and likewise expressly [held] that a mis-diagnosis does not equate to a medical determination under the statute. That is, if a miner's claim is ultimately rejected on the basis that he does not have the disease, this finding necessarily renders any prior medical opinion to the contrary invalid and the miner is handed a clean slate for statute of limitations purposes. If he later contracts the disease, he is able to obtain a medical opinion to that effect, when then re-triggers the statute of limitations.

Dukes, slip op. at 5, relying upon *Wyoming Fuel Co. v. Director, OWCP [Bandolino*], 90 F.3d 1502, 1507 (10th Cir. 1996).

I have adopted the reasoning of the *Dukes* court in this case. Claimant filed his first claim for benefits on December 28, 1979, after Dr. Leslie diagnosed pneumoconiosis and stated that he was disabled for work. DX 42-16; Tr. 25 – 27. The Director denied the claim. DX-42-2. The record does not establish that the initial claim was denied because of the weight accorded to Dr. Leslie's opinion, but rather reflects that Claimant failed to establish the elements of entitlement to benefits. Id. Applying the *Dukes* rationale, I find that Dr. Leslie's opinion is invalid, and constitutes an unsupported medical determination that resulted in Claimant's premature claim. Accordingly, the doctor's invalid opinion is not the trigger for the commencement of the statute of limitations.

Therefore, I find that the instant subsequent claim is not time-barred.

D. Length of Coal Mine Employment ("CME")

In his prior decision, ALJ Teitler concluded that Claimant had established 12 years and 4.5 months of CME. The parties have not challenged this finding, and my review of the record reflects that the evidence supports it. However, the Board, in its remand Decision and Order, has directed that I consider the consistency of this finding with the length of CME relied upon by medical experts when weighting their opinions.

In rendering their opinions, the medical experts of record consistently relied upon 19 or 20 years of CME, 18 of which were spent underground, as reported by Claimant. Claimant similarly testified to this length of CME. However, I find that the best evidence, including Claimant's social security account records, supports ALJ Teitler's conclusions. I further find that the discrepancy between the CME of record and the amount of time considered by the medical experts is of little significance to their overall determination regarding the existence of pneumoconiosis and its relationship to pulmonary disability. In reaching this conclusion, I note that the two experts asked to consider CME of less than 20 years both testified that ten years of exposure to coal dust inhalation was considered a "prolonged period of exposure" (Dr. Fino, EX-8 at 4) sufficient to contract CME (Dr. Broudy, EX-10, at 15-16). Therefore, a finding of more than 12 years would be significant and its difference from Claimant's stated years of CME would not compromise a medical opinion so as to deprive it of probative value.

E. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under the Part 718 standards. § 718.2. In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of CME, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. *See generally Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994); *see also* §§ 718.201 – 718.204.

The instant claim was filed more than one year after the previous claim was finally denied. Therefore, this claim must be denied unless Claimant demonstrates that one of the applicable conditions of entitlement has changed since the denial of the prior claim. 20 C.F.R. § 725.309(d). Section 725.309(d) also provides that the following rules shall apply in adjudicating subsequent claims[3]:

> (1) Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, … if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. …

[3] The terms "subsequent claim" and "duplicate claim" are synonymous. 20 C.F.R. § 725.309 (2001).

> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim.

§ 725.309(d).

Under the subsequent claim provisions, the instant claim must be denied for the same reasons as Claimant's 1979 claim unless there was a material change in conditions after the denial of the earlier claim. § 725.309. In order to determine whether a material change of condition has occurred,

> the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change.

Sharondale Corp. v. Ross, 42 F.3d 993, 997-998 (6th Cir. 1994). "A 'material change' exists only if the new evidence both establishes the element and is substantially more supportive of the claimant." *Kirk*, supra., at 609. The ALJ must explain how the new evidence demonstrates a worsening of the claimant's condition. *Flynn v. Grundy Mining Co*., supra. In compliance with the Board's Decision and Order, I shall consider whether the new evidence submitted with the subsequent claim differs qualitatively from evidence submitted with the previously denied claim.

F. Medical Evidence of Record

The current record contains the X-ray interpretations summarized in the following table.[4]

DATE OF X-RAY	DATE READ	EX NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	INTERP.
2/21/80	8/27/87	DX-36	Quillin	BCR, B	0/0
2/21/80	9/1/87	Dx-35	Binns	B	0/1, p/s
2/21/80	8/17/87	DX-34	Broudy	B	Negative
2/21/80	9/3/87	Dx-35	Gogiveni	B	Negative
4/3/80	7/5/88	DX-49	Halbert	BCR, B	Negative
4/3/80	6/21/88	DX-48	Lane	B	Negative
4/3/80	6/17/88	DX-46	Broudy	B	Negative
10/15/86	10/15/86	DX-13	Williams	--	1/1, p/s

[4] A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51. A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001).

10/15/86	11/26/86	DX-12	Elmer	BCR, B	Negative
10/15/86	11/6/86	DX-11	Cole	BCR, B	1/1, q/s
10/15/86	6/24/87	DX-31	Binns	B	Negative
10/15/86	6/29/87	DX-31	Gogiveni	B	Negative
10/15/86	6/21/86	DX-30	Quillin	BCR, B	Negative
10/15/86	6/17/87	DX-29	Broudy	B	Negative
2/26/87	8/28/87	DX-37	Quillin	BCR, B	0/0
2/26/87	8/9/87	DX-33	Jarboe	--	0/0
2/26/87	7/24/87	DX-32	Broudy	B	Negative
4/6/87	4/6/87	DX-24	Broudy	B	Negative
4/6/87	4/14/87	DX-25	Quillin	B	Negative
4/6/87	6/4/88	DX-45	Lane	B	Negative
4/6/87	6/17/88	DX-47	Wershba	--	Negative
4/6/87	6/18/88	DX-47	Gogineni	B	0/0
4/6/87	6/22/88	DX-47	Binns	B	Negative
9/13/93	9/15/93	DX-59	Halbert	BCR, B	Negative
9/13/93	9/28/93	DX-58	Sargent	B	0/0
5/26/94	5/26/94	DX-67	Westerfield	B	1/0; p/p
5/26/94	12/29/94	DX-67	Binns	B	0/0
5/26/94	12/30/94	DX-67	Abramowitz	--	0/0
5/26/94	1/3/95	DX-67	Gogineni	B	0/0
5/26/94	1/12/95	DX-67	Wershba	--	0/0
1/9/95	1/23/95	DX-67	Ahmed	BCR, B	1/0; p/p
1/9/95	1/9/95	DX-67	Sundaram	A reader	1/1; p/q
1/9/95	1/10/95	DX-67	Reddy	BCR	1/1; p/q
1/9/95	11/14/95	EX-12	Abramowitz	--	0/0
1/9/95	11/17/95	EX-12	Wershba	--	Unreadable
1/9/95	11/22/95	EX-12	Binns	B	Unreadable
1/9/95	10/4/95	DX-69	Sargent	BCR, B	0/0
11/20/95	12/18/95	EX-12, 13	Vuskovich	B	0/0

The x-ray evidence submitted with the Claimant's initial claim for benefits is summarized below:

DATE OF X-RAY	DATE READ	EX NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	INTERP.
12/14/79	12/14/79	DX-42	Leslie	Unknown	1 /2
12/14/79	12/14/79	DX-42	Adams	Unknown	Fibro-nodular Densities
1/11/80	1/11/80	DX-42	Penman	Unknown	1 /2
1/18/80	1/18/80	DX-42	Anderson	BCR, B	Cat. 1
2/11/80	2/11/80	DX-26	Combs	BCR, B	0/0
2/21/80	1/23/81	DX-42	Cole	BCR, B	1/0
2/21/80	2/21/80	DX-39	Wright	Unknown	2/1
4/3/80	4/3/80	DX-42	White	Unknown	Interstitial pulmonary disease
4/3/80	10/22/80	DX-42	Cole	BCR,B	Negative
4/7/80	6/20/80	DX-42	Marshal	BCR,B	Negative
4/28/80	4/28/80	DX-42	Quillen	BCR,B	Negative

The current record contains the pulmonary function studies ("PFTs") summarized below.

DATE	EX. NO.	PHYSICIAN	AGE	FEV_1	FVC	MVV	FEV_1 FVC	EFFORT	QUALIFY
1/18/80	DX24	Branscomb (reviewer)	39	2.60	4.10	106.2		Inadequate	No
1/18/80	CX1, 2	Cohen (reviewer)	39	2.60	4.10	106.2			No Valid study
1/18/80	DX67	Fino (reviewer)	39	2.60	4.10	106.2			No Valid study
2/17/80	CX-1	Cohen (reviewer)	39	2.12	3.68	78	57.6	Satisfactory	No Valid study
2/17/80	DX67	Fino (reviewer)	39	2.12	3.68	78	57.6		No Valid study
4/3/80	CX-1	Cohen (reviewer)	39	2.24		102			Tracings not legible
4/3/80	DX67	Fino (reviewer)	39	2.24		102			No Valid study
10/15/86	DX8	Williams	46	2.36	3.92	87		Fair/good	No Valid study
10/15/86	CX1	Cohen (reviewer)	46	2.36	3.92	87		Good	No Valid study
10/15/86	DX67	Fino	46	2.36	3.92	87			No Valid study
2/26/87	DX23	Dahhan	47	2.65 2.7*	3.95 3.9*	132			No Valid study
2/26/87	DX67	Branscomb (reviewer)	47	2.65 2.7*	3.95 3.9*	132		Mild changes	No
2/26/87	CX-1	Cohen (reviewer)	47	2.65 2.7*	3.95 3.9*	132			No
2/26/87	DX67	Fino (reviewer)	47	2.65 2.7*	3.95 3.9*	132			No Valid study
4/6/87	DX24 DX28	Broudy	47	2.55	4.08	100			No Valid study
4/6/87	CX-1	Cohen (reviewer)	47	2.55	4.08	100			No
4/6/87	DX67	Fino (reviewer)	47	2.55	4.08	100			No Valid study
9/9/93	DX55	Mettu	53	1.23	2.34	42		Good	Yes
9/9/93	DX55	Kraman,BCR	53						Vents acceptable
9/9/93	DX67	Branscomb (reviewer)	53	1.23	2.34	42			Yes Not valid
9/9/93	DX67	Broudy (reviewer)	53	1.23	2.34	42			Yes Valid study
9/9/93	DX67	Fino (reviewer)	53	1.23	2.34	42			Not valid
5/26/94	DX67	Westerfield	54	1.51 1.69*	3.08 3.30*	50 60*		Good	Yes Valid Study
5/26/94	CX-1	Cohen (reviewer)	54	1.51 1.69*	3.08 3.30*	50 60*			Yes valid study
1/9/95	DX67	Sundaram	54	1.48	2.68	53			Yes Valid study

1/9/95	EX5	Branscomb (reviewer)	54	1.48	2.68	53			Test did not conform
1/9/95	CX1	Cohen (reviewer)	54	1.48	2.68	53			Yes Valid study
11/18/95	EX2 EX13	Vuskovich	55	1.69	2.96		57%	Good	No Valid study
11/18/95	CX-1	Cohen (reviewer)	55	1.69	2.96		57%		No Valid study

*post-bronchodilator

The record submitted with Claimant's prior claim contains the pulmonary function studies summarized below.

DATE	EX. NO.	PHYSICIAN	AGE	FEV_1	FVC	MVV	FEV_1 FVC	EFFORT	QUALIFY
1/18/80	DX26	Anderson	39	2.60	4.10	106.2			No
4/3/80	DX42	Sutherland	39	2.24		102			No Valid study
2/27/80	DX42	Anderson	39	2.12	3.68	78		Satisfactory	

The current record contains the arterial blood gas studies ("ABGs") summarized below.

DATE	EX. NO.	PHYSICIAN	pCO2	pO2	QUALIFIES
10/15/86	DX10	Williams	39.6 42.1*	84.0 92.1*	No No*
2/26/87	Dx23	Dahhan	45.7	77.1	No
4/6/87	DX24	Broudy	33.2	84.4	No
9/9/93	DX57	Mettu/Denny	34.5	67.3	No
5/26/94	DX67	Westerfield	35	68	No
11/18/95	EX2; 13	Vuskovich	39.0	72.7	No

*post-exercise

The arterial blood gas study evidence summarized below was submitted with Claimant's prior claim.

DATE	EX. NO.	PHYSICIAN	pCO2	pO2	QUALIFIES
1/18/80	DX26	Anderson	34.6	78.9	No
4/3/80	DX42	Sutherland	34.1 31.6*	89.9 99.5*	No No*
2/27/80	DX42	Wright	34.7	70.3	No

*post-exercise

The current record contains the medical opinions summarized below.

Dr. Cordell H. Williams (DX-9)

Dr. Williams examined Claimant on October 15, 1986, and recorded Claimant's medical history of peptic ulceration. The doctor documented that Claimant had worked underground in the mines for 20 years, and smoked ½ pack of cigarettes a day for 30 years. The doctor's examination revealed rhonchi and prolongation of expiration with wheezing. Moderate expiratory rales were present over both lung fields. Dr. Williams concluded that an X-ray was positive for pneumoconiosis and diagnosed chronic obstructive pulmonary disease with 1/1 p/s pneumoconiosis, related to CME. The doctor found that Claimant had moderate pulmonary impairment and was unable to resume his former CME.

Dr. Abdul Kader Dahhan (DX-23, 27, 67; EX-3, 14)

Dr. Dahhan (board certified in internal and pulmonary medicine, B-reader) examined Claimant on February 26, 1987. In his report of March 2, 1987, Dr. Dahhan documented Claimant's medical history of peptic ulcer disease and his symptoms of dyspnea on exertion and occasional edema in the morning. The doctor recorded that Claimant worked as a miner for 19 years, and had smoked ½ pack of cigarettes daily since he was 20 years old. The doctor's examination revealed scattered rhonchi and expiratory wheezing. An electrocardiogram was normal, as was an arterial blood gas study. The doctor found that an X-ray was negative for pneumoconiosis, and he diagnosed Claimant with chronic bronchitis. Dr. Dahhan attributed the mild obstructive changes evident on a pulmonary function study to Claimant's smoking history. The doctor concluded that Claimant could return to his former work in coal mining.

Dr. Dahhan testified at deposition that Claimant's expiratory rhonchi and wheezing are more compatible with bronchitis than with coal worker's pneumoconiosis, which generally produces no evidence of bronchospasm. DX-27 at 14. Dr. Dahhan testified at a second deposition on January 17, 1995, and observed that Claimant had an obstructive impairment that was not disabling. In his opinion, Claimant's impairment was not consistent with the restrictive nature of an impairment caused by pneumoconiosis. The doctor conceded that industrial bronchitis can result from coal dust inhalation, but said that this manifestation usually ceases within a short time after exposure is terminated. Because Claimant's last exposure to coal dust was in 1979, Dr. Dahhan believed that his impairment was more consistent with another cause. The doctor concluded that Claimant's chronic bronchitis was due to his smoking, which he found from the evidence to be at least ½ pack per day for 10 years, and at most ½ pack per day for 30 years.

In his report of December 27, 1995, the doctor summarized his review of additional medical records and concluded that the evidence did not demonstrate the presence of pneumoconiosis. Dr. Dahhan observed that pneumoconiosis usually produces a restrictive pulmonary impairment, and is manifested by crackles and opacities on X-ray, and reduced FVC and FEV1 that is proportionate. He found that the evidence was not consistent with such findings, although he did conclude that the most recent pulmonary function study results demonstrated that Claimant would not be able to perform hard manual labor.

Dr. Bruce C. Broudy (DX-24, 28, 57, 67; Ex-4, EX-10; 15.)

Dr. Broudy (board certified in internal and pulmonary medicine, B-reader) examined Claimant on April 6, 1987, and documented his medical and personal histories in his report of that date. The doctor recorded that Claimant had a history of smoking ½ to 1 pack of cigarettes per day for 30 years, and his work as a miner for 20 years, 18 of which were performed underground. The doctor's examination revealed coarse inspiratory and expiratory rhonchi that cleared to some degree with coughing. The doctor observed no significant expiratory delay. An arterial blood gas study and electrocardiogram were normal. Dr. Broudy read an X-ray as negative for pneumoconiosis. A pulmonary function test revealed mild obstruction that Dr. Broudy attributed to smoking. He found no evidence of pneumoconiosis and diagnosed chronic bronchitis. In Dr. Broudy's opinion, Claimant had the pulmonary capacity to resume his former CME.

Dr. Broudy was deposed on May 19, 1987, and testified about the results of his examination of Claimant. The doctor reiterated that the objective evidence supported a diagnosis of chronic bronchitis with mild airway obstruction, related to his cigarette smoking habit. Dr. Broudy testified that Claimant would have experienced the bronchitis as a result of cigarette smoking "whether or not he had been employed in the coal mining industry". DX-28 at 17. The doctor acknowledged that a history of even 10 years exposure to coal dust inhalation would be sufficient time to contract pneumoconiosis. Id. at 19-20. He admitted that Claimant's reported symptoms were compatible with a diagnosis for pneumoconiosis, but explained that the symptoms were non-specific. Dr. Broudy stated that his opinion that Claimant could return to his work would remain unchanged by a finding that X-ray established the presence of pneumoconiosis. Id. at 23.

Dr. Broudy conducted a review of the medical record and issued a report on July 22, 1988 that concluded that Claimant did not have pneumoconiosis. The doctor relied on the X-ray evidence, which he concluded showed mostly negative findings. He concluded that the arterial blood gas studies showed only mild resting hypoxemia, and that pulmonary function studies revealed a mild to at most moderate obstructive airways disease, that he believed was most likely caused by Claimant's smoking. He concluded that Claimant retained the capacity "to perform the work of an underground coal miner or to do similarly arduous manual labor". DX-51.

In a report of December 12, 1994, Dr. Broudy reviewed the medical reports and opinions of other doctors, specifically Drs. Mettu and Leslie, and refuted their opinions, stating that he still found no evidence of pneumoconiosis. Dr. Broudy agreed that Claimant's lung function had progressively deteriorated since 1987, but said that the cause of his impairment was chronic obstructive airways disease and perhaps bronchial asthma. He found that Claimant would be unable to perform his work as a coal miner, but concluded that the etiology of Claimant's impairment was his cigarette smoking.

Dr. Broudy testified at deposition on January 19, 1995, and again restated his opinion that the medical evidence does not demonstrate that Claimant has an occupational disease. Dr. Broudy attributed Claimant's impairment to chronic obstructive airways disease due to cigarette smoking. The doctor addressed the pulmonary function study performed by Claimant on

September 9, 1993, and stated that in his opinion, in consideration of that evidence, Claimant could not perform hard manual labor. He stated that an FEV1 of 84% would be sufficient to allow Claimant to perform work, and even at 70%, Claimant would be capable of performing coal mine employment.

In his report of December 26, 1995, Dr. Broudy summarized his review of additional medical records, and again concluded that Claimant has moderate chronic obstructive airways disease caused by cigarette smoking. The doctor also recognized the potential for the effects of a component of bronchial asthma. EX-4; 15.

Dr. R.V. Mettu (DX-56; 60)

Dr. Mettu examined Claimant on September 9, 1993, and documented his history of cough and exertional shortness of breath. The doctor's physical examination was unremarkable, and an electrocardiogram was normal. The doctor recorded that Claimant smokes between 4 and 6 cigarettes daily since 1978, and worked in the mines for about 20 years. The doctor observed that arterial blood gas studies and pulmonary function tests produced results that were consistent with severe pulmonary impairment. Dr. Mettu concluded that the studies showed obstructive airway disease, but added that a component of restrictive airway disease could also be present.

In his supplemental report of November 12, 1993, the doctor concluded that Claimant's pulmonary impairment "could be related to occupational exposure" despite X-rays that are negative for pneumoconiosis. He wrote that etiology factors for pulmonary impairment include working in the coal mines and smoking. The doctor found Claimant totally disabled due to a respiratory impairment that he identified as COPD or chronic bronchitis.

Dr. B.T. Westerfield (DX-67)

Dr. Westerfield (board-certified in internal and pulmonary medicine, B-reader) examined Claimant on May 26, 1994 and documented his medical and personal histories, including a 19 year history of working in coal mining. The doctor noted that Claimant reported smoking since he was 16 years old, and smoked ¼ pack of cigarettes a day, averaging about ½ pack of cigarettes over a 25 pack year history of smoking. His examination revealed generally decreased breath sounds, with scattered rhonchi over both lung fields which did not clear after coughing, which was frequent during the examination. He found an X-ray positive for pneumoconiosis, and pulmonary function study revealed moderate obstructive ventilatory dysfunction that improved significantly after administration of bronchodilator. Arterial blood gas study results showed mild oxygen desaturation on room air at rest. Dr. Westerfield diagnosed pneumoconiosis based upon his positive X-ray, and concluded that he would be unable to return to CME due to COPD.

Dr. Ben Branscomb (DX-67)

Dr. Branscomb (board-certified in internal medicine) reviewed the medical evidence and issued a report on December 21, 1994, wherein he concluded that the X-ray evidence does not demonstrate the presence of pneumoconiosis. The doctor noted Claimant's 19 to 20 years of

CME, eighteen of which were spent underground. Dr. Branscomb also summarized the record references to Claimant's cigarette habit, which was documented variably as ½ pack daily since the age of 30; ½ pack daily since the age of 17; 4 to 6 cigarettes daily for fifteen years. The doctor concluded that "pulmonary and cardiovascular disorders would commonly occur" as the result of a smoking history such as Claimant's. The doctor's review of the X-ray evidence led him to conclude that pneumoconiosis was not established. He found that if valid, the pulmonary function test evidence showed that a temporary condition was responsible for lower values. He was particularly skeptical of the validity of a test performed on September 9, 1993, because the values were so low as compared to other values. The doctor wrote:

> There is no way Dr. Mettu's lower values could be caused by a chronic condition such as CWP [(pneumoconiosis)]. CWP is not a reversible process and lung function cannot abruptly drop from fully normal values confirmed on four or five consecutive tests to severe reduction. Furthermore, there is no way such an abrupt change fourteen years after leaving coal mining could result from some late influence of the earlier dust exposure.

DX-67. Dr. Branscomb also discounted the abnormal blood gas test of September 3, 1993, and found that it reflected a temporary condition, as it occurred concurrently with an abrupt drop in values on pulmonary function tests of that date. The doctor concluded that Claimant did not have pneumoconiosis or other occupational pulmonary disease, and found him able to return to his past CME. The doctor found that Claimant had symptoms of chronic bronchitis due to his cigarette smoking. He denied that his past coal dust exposure influenced his current pulmonary function.

Dr. Branscomb testified at deposition on January 23, 1995, and acknowledged that Claimant's symptoms of cough, phlegm expectoration, wheezing, shortness of breath, orthopnea, nocturnal dyspnea, rales, and rhonchi could be related to pneumoconiosis. DX-67, deposition at 23-24. The doctor admitted that Claimant had "mild, intermittent, non-disabling pulmonary impairment". Nevertheless, the doctor concluded that Claimant's symptoms, and chronic bronchitis were unrelated to the inhalation of coal dust, and he stated: "I would expect that he would have no impairments whatsoever if he totally stopped smoking". Id. at 27-28. The doctor concluded that coal dust could not cause the drop in pulmonary function that was demonstrated by tests in late 1993 and then in 1995, because Claimant's exposure to coal dust ended in 1979. He did not believe that a return to CME would affect Claimant other than to result in more coughing and spitting. The doctor conceded that simple pneumoconiosis could disable an individual from CME.

In his report of January 2, 1996, the doctor noted that his review of additional medical evidence did not change his opinion that Claimant has no pulmonary condition related to coal dust exposure. Dr. Branscomb concluded that Claimant "probably has mild intermittent symptoms from chronic bronchitis", which he said was caused solely by his smoking. The doctor again opined that Claimant's functioning would improve with cessation of smoking and proper therapy. EX-5.

Dr. William H. Anderson (DX-67)

Dr. Anderson (board certified in internal and pulmonary medicine) summarized the medical evidence in his report of December 28, 1994. The doctor noted that of 43 chest X-ray readings, one set was unreadable, two made no mention of pneumoconiosis, six were positive for pneumoconiosis, and the remainder (34) were negative for pneumoconiosis. The doctor reviewed ten sets of pulmonary function studies, of which one qualified as sufficiently low to meet the disability standards, and three were entirely normal. The test of April 3, 1980 could not be validated and the rest of the tests (5) showed mild decrease in function, mostly in the FEV1. The eight arterial blood gas studies produced normal or near normal results.

Dr. Anderson testified at deposition on January 17, 1995, and elaborated on the findings in his report. The doctor noted that he had read one of the X-rays himself as positive, and admitted that additional exposure to coal dust would increase Claimant's shortness of breath. However, Dr. Anderson believed that the evidence did not establish that Claimant has a respiratory impairment as a result of his CME. DX-67, deposition at 26. The doctor admitted that a pulmonary function test that he administered produced abnormal results, but stated that Claimant retained the ability to perform his CME. Id. at 29-30. The doctor noted that Claimant's level of impairment would permit him to perform most of the jobs of his CME. Id at 30.

The doctor concluded that Claimant's reduction in function studies "was due to an obstructive defect that was of variability" and distinguished it from pneumoconiosis because that condition "is permanent and fixed". Id. at 32. He attributed Claimant's condition to cigarette smoking, and agreed that his diminished pulmonary state would have occurred regardless of environmental exposure.

Dr. Gregory J. Fino (DX-67; EX-6, 7)

Dr. Fino (board certified in internal and pulmonary medicine; B-reader) reviewed the medical evidence, which he summarized and discussed in his report of December 29, 1994. Dr. Fino documented Claimant's smoking history of ½ pack per day since at least 1970, with contradictory documentation of his smoking a full pack daily in 1993, reduced to 4 to 5 cigarettes a day by October of that year. The doctor concluded that the objective evidence did not establish that Claimant had a pulmonary condition caused by coal dust exposure. Dr. Fino noted that the majority of X-ray readings were negative for pneumoconiosis, and that the arterial blood gas studies did not reveal an impairment of oxygen transfer because hypoxemia was not evident. He concluded that Claimant's respiratory defect was purely obstructive, and more consistent with conditions such as smoking, emphysema, chronic bronchitis and asthma. He invalidated the pulmonary function test of 1992, and concluded that his respiratory impairment was not at a level sufficient to render him partially or totally disabled from his last CME.

Dr. Fino testified at deposition on January 16, 1995, and noted that a lung volume study produced results that were the opposite of what he would expect from a condition caused by coal dust inhalation. The doctor's opinion was that the variability of the pO2 results on blood gas studies showed variations that were consistent with diseases caused by cigarette smoking, and

not with the permanent scarring and fibrosis associated with pneumoconiosis. He noted that there was no decrease in oxygenation with exercise in blood gas studies performed in 1980 and 1986, and further observed that Claimant continued to smoke during the years from 1987 to 1993, when his pulmonary function studies showed increase in defect. Because Claimant had stopped working in the mines in 1979, Dr. Fino found that smoking was responsible for the decline in Claimant's functioning. DX-11-15; 23-24.

Dr. Fino undertook another review of the medical record, and issued a report dated January 2, 1996, wherein his opinion remained unchanged. He maintained that the records demonstrate a mild respiratory impairment that was caused by Claimant's smoking and that was not disabling. Dr. Fino's opinion was that Claimant's pulmonary abnormality is purely obstructive and reversible, as demonstrated by improvement after administration of bronchodilators. Dr. Fino acknowledged that coal dust exposure may cause a reduction in the FEV1, but asserted that the reduction would be minimal and clinically insignificant. In his opinion, obstruction is diagnosed by a reduction in the FEV1/FVC ratio, which does not relate to coal dust inhalation.

In his report of February 12, 1996, Dr. Fino addressed Dr. Cohen's report of December 15, 1995, and refuted Dr. Cohen's opinion regarding the reason for Claimant's less than maximum exercise study. Dr. Fino attributed the drop in pO2 to deconditioning and less than maximum effort, rather than to shortness of breath. Dr. Fino explained that pneumoconiosis would generally cause an oxygen transfer abnormality rather than a ventilatory impairment, and said that Claimant's symptoms were non-specific and indicative of a variety of conditions, but more consistent with smoking than coal dust inhalation. In the doctor's opinion, an individual who does not have impairment of function due to coal dust inhalation when he leaves the mine will not develop functional impairment in the absence of further coal mine dust exposure. He again attributed the loss of function to Claimant's continued smoking. EX-7.

Dr. Raghu R. Sundaram (DX-67; EX-8)

Dr. Sundaram (board-certified in internal medicine and pulmonary medicine; A-reader), examined Claimant on January 9, 1995, and recorded Claimant's medical and personal histories, including his CME of over 20 years and his smoking of 3 cigarettes per day. His examination revealed rhonchi and wheezes, and he found that an X-ray was positive for pneumoconiosis. Dr. Sundaram also conducted a pulmonary function study, and he concluded that Claimant has pneumoconiosis due to his CME. In his opinion, Claimant is unable to perform his CME.

The doctor testified at deposition on March 5, 1996, and stated that his opinion would not change considering a smoking history of ½ pack per day for 26 years. Dr. Sundaram acknowledged that many other diseases have similar manifestations as pneumoconiosis, and admitted that pneumoconiosis most often causes restrictive impairment while smoking causes obstruction. However, the doctor remained firm in his opinion that Claimant's condition is due to coal dust exposure, and said that his conclusion is consistent with X-ray findings, his examination, and his work history. The doctor again stated that Claimant is totally disabled from performing hard manual labor due to pneumoconiosis.

Dr. Matt Vuskovich (DX-67; EX-2, 13)

Dr. Vuskovich (B-reader), examined Claimant on November 18, 1995, and documented his symptoms of exertional dyspnea and cough, as well as occasional dyspnea and wheeze. Claimant's CME of 20 years was documented, as was his history of smoking ½ pack of cigarettes daily, reduced to 3 to 4 a day at the time of the examination. The doctor's examination revealed rales and wheezing throughout both lung fields, but an X-ray was negative for pneumoconiosis. Pulmonary function testing produced results consistent with a moderate obstructive impairment, and an arterial blood gas study showed mild hypoxemia. The doctor diagnosed chronic obstructive pulmonary disease (COPD) secondary to cigarette smoking, and moderate pulmonary impairment. Dr. Vuskovich found no evidence of pneumoconiosis, but concluded that Claimant would have difficulty performing heavy manual labor. Dr. Vuskovich did not place the work of a scoop operator in that category. In the doctor's opinion, Claimant would experience improvement in pulmonary function if he stopped smoking and underwent therapy.

In finding that Claimant's pulmonary impairment was caused by smoking, Dr. Vuskovich relied upon tests that showed that the impairment is obstructive in nature, as opposed to restrictive. The doctor explained that the progressive fibrosis associated with pneumoconiosis causes impairment that is usually restrictive in nature. Dr. Vuskovich reiterated his opinion in his statement of December 27, 1995.

Dr. Robert A. C. Cohen (CX-1, 2, 3)

Dr. Cohen (board certified in internal and pulmonary medicine) reviewed the medical record and in his report of December 15, 1995, concluded that Claimant has pneumoconiosis. In support of his opinion, Dr. Cohen cited Claimant's occupational history of 15 to 20 years in coal mining, with all but two underground. The doctor documented Claimant's reported smoking habit of 2-3 cigarettes a day, and his past average habit of ½ pack per day for a total of 21 years. The doctor noted his symptoms of shortness of breath and his arthritis. The doctor summarized the medical evidence of physical examinations and objective test results. Although Dr. Cohen did not examine Claimant, he observed that most examinations of record revealed wheezing and rhonchi. The doctor observed that pulmonary function studies showed obstructive lung disease, and resting blood gas studies showed abnormalities with gas exchange. He also noted that some of the X-rays of record were positive for pneumoconiosis, and he denied the possibility of any other occupational exposure or cause of obstructive lung disease except Claimant's smoking habit.

Dr. Cohen rejected the hypothesis that coal dust inhalation produces only a restrictive pattern of lung disease. He related Claimant's impairment to both his CME and his five to fifteen pack year exposure to tobacco, and found the impairment disabling for his CME. He concluded that the blood gas studies were not normal and demonstrated results that were significantly below what one would expect for an individual of Claimant's age.

In his supplemental report of February 19, 1996, Dr. Cohen addressed his review of additional medical records and the contrary opinions of other medical experts. He again rejected

the opinion that coal dust inhalation would be purely restrictive in nature, and pointed out that the lack of significant improvement after bronchodilators demonstrates that his obstructive defect has a permanent component. He stated that his understanding of the generally accepted medical research showed that reductions in FEV1 due to smoking cigarettes was almost half of the reduction typically caused by exposure to coal dust during the years when Claimant was employed in the industry. Dr. Cohen reiterated his opinion that Claimant suffers from disabling pneumoconiosis, based upon his 15 to 20 year history of CME. He observed that his opinion is supported by positive X-rays, but said that his opinion remains unswerved by the evidence of negative X-rays. He relied upon the numerous pulmonary function tests that he found consistently demonstrated obstructive defects, and his abnormal gas exchanges, for which he found "only two possible causes…one is his very modest 5 to 15 pack year history of tobacco smoking, the other his 15 to 20 years of significant exposure to coal dust". CX-3.

Dr. Larry Leslie (CX-4)

By affidavit executed on September 27, 1997, Dr. Leslie asserted that he had treated Claimant since 1979 for his respiratory impairment, and stated: "[i]n my opinion, Mr. Montoya [sic] suffers from coal worker's pneumoconiosis as I understand the disease." The doctor further stated that he believed Mr. Case's' "exposure to coal dust while working in the coal mines between 15 and 20 years contributed to cause this condition". He further asserted that Claimant's pneumoconiosis is the cause of his disabling respiratory impairment that prevents him from performing his CME.

Dr. Peter G. Tuteur (EX-16)

Dr. Tuteur (board certified in internal and pulmonary medicine) summarized the evidence of record, and noted his CME of nearly 20 years. The doctor also observed that the record reflected that Claimant began smoking at the age of 16, and continued to smoke at the time of his medical evaluation in 1995, at variable rates ranging from ½ pack to one pack a day. Dr. Tuteur referred to documentation by Claimant's treating physician (Dr. Leslie) that he smoked up to one pack per day. Claimant's medical history is also documented, and Dr. Tuteur notes that although the record refers to Claimant's treatment for his breathing problems with pills and liquids, those medications were not defined to him. The doctor observed that Claimant's pulmonary function studies in 1980 were normal, and returned to baseline in 1987 after a not necessarily valid fall. He notes that studies show an obstructive defect in 1993 that improved in 1995. Arterial blood gas studies also revealed declines and rises, but never produced more than mildly abnormal results. The doctor's review of the X-ray evidence showed that most were negative for the presence of changes consistent with pneumoconiosis.

Dr. Tuteur recognized that breathlessness is a symptom significantly associated with pneumoconiosis, but he also observed that it is a nonspecific finding consistent with most pulmonary conditions. He concluded that Claimant's other subjective symptoms of cough, expectoration and chest pain are consistent with chronic bronchitis, which is induced by smoking cigarettes. The doctor agreed that although an obstructive defect could result from pneumoconiosis, and that bronchitis could result from inhalation of coal dust, such is not a regular occurrence. The doctor found that the evidence revealed a pattern typical for smoke-

induced bronchitis, and noted that the persistence of findings that one would expect to see with irreversible pneumoconiosis is not present in the record.

In his report, Dr. Tuteur summarized the conclusions and opinions of researchers who examined the effects of dust exposure and smoking in miners. The doctor concluded that in consideration of the medical data of record, along with the medical literature available to him, Claimant does not have clinically significant coal workers' pneumoconiosis. Even accepting those X-rays that showed the presence of simple pneumoconiosis, the doctor believed it would be of insufficient severity and profusion to produce a measurable impairment of pulmonary function. The doctor did find "though he has impairment of function due to chronic inhalation of tobacco smoke, he is neither disabled in whole or in part to the inhalation of coal mine dust or the development of coal workers' pneumoconiosis." The doctor found no basis for concluding that Claimant's ventilatory defect was related to, caused by or aggravated by either the inhalation of coal dust or the development of pneumoconiosis.

The medical opinion evidence submitted with Claimant's initial claim is summarized as follows:

Dr. James D. Adams (DX 42)

Dr. Adams examined Claimant while he was still working, and in his report of December 14, 1979, recorded his medical history of bleeding peptic ulcer and noted his symptoms, including dyspnea. The doctor recorded a 20 year history of underground mining, and documented his smoking history of ½ pack of cigarettes per day for 8-9 years. An X-ray showed bilateral fibronodular densities. After his examination, which disclosed a slight degree of clubbing of the fingernails, Dr. Adams concluded that Claimant had chronic obstructive airway disease. The doctor diagnosed silicosis and recommended that Claimant avoid further exposure to a dusty environment.

Dr. Larry M. Leslie (DX-42)

Dr. Leslie examined Claimant on December 14, 1979 while he was still working, and noted his reported symptoms of shortness of breath upon exertion. The doctor recorded a CME of 20 years underground, and observed that Claimant smoked ½ pack of cigarettes per day, but did not record the length of his smoking habit. The doctor found wheezing upon his examination of Claimant, and he concluded that an X-ray was positive for pneumoconiosis. The doctor concluded that Claimant should not return to underground mining, finding him disabled from performing any "strenuous, heavy, manual labor".

Dr. Robert Penman (DX-42)

Dr. Penman (pulmonary medicine Department of Bethesda Hospital) examined Claimant and issued a report on January 11, 1980, in which he documented Claimant's 20 year history in the mines, and his smoking habit of ½ pack of cigarettes daily "for many years". An X-ray was read positive for pneumoconiosis, and pulmonary function testing revealed airway obstruction. Dr. Penman concluded that considering Claimant's CME and X-ray, a diagnosis of

pneumoconiosis stage I progressing to stage II was appropriate. The doctor also found that Claimant's pulmonary function was impaired.

Dr. William H. Anderson (DX-42)

Dr. Anderson (board-certified in internal and pulmonary medicine) examined Claimant on January 18, 1980, and in his report of January 28, 1980, noted his 20 year history of working underground in the mines. His smoking habit of ½ pack per day for about nine years was recorded. The doctor's physical examination was normal, as was an electrocardiogram. An X-ray was positive for category 1 pneumoconiosis. Pulmonary function and blood gas studies were performed, and upon his review of his examination and findings, Dr. Anderson diagnosed early category 1 pneumoconiosis and psychoneurosis with episodes of hyperventilation.

Dr. Allen L. Cornish (DX-26; 42)

Dr. Cornish (board certified in internal medicine) examined Claimant on April 28, 1980, and recorded a history of CME of 20 years duration. The doctor's report notes that Claimant "has smoked a half pack of cigarettes a day for many years". The doctor reviewed the results of X-rays, electrocardiogram, blood gas study, and pulmonary function test and found no evidence of silicosis or other occupational disease. Dr Cornish diagnosed hypertension and chronic bronchitis. In his deposition testimony of July 3, 1980, Dr. Cornish attributed Claimant's chronic bronchitis to his cigarette smoking.

Dr. Ballard D. Wright (DX-42)

Dr. Wright examined Claimant on February 21, 1980 and documented a coal mine history of 20 years, and a smoking history of ½ pack per day for nine years. The doctor found expiratory wheezing on forced expiration. An X-ray was read as positive for pneumoconiosis. Pulmonary function study revealed moderate obstructive airway defect, and arterial blood gas study showed moderate resting hypoxemia. Dr. Wright diagnosed COPD, pneumoconiosis, category 2 simple, and peptic ulcer disease. The doctor found that Claimant had chronic bronchitis associated with smoking and inhalation of respiratory dust, and concluded that he should not be exposed to coal dust.

Dr. J. W. Sutherland (DX-42)

Dr. Sutherland (board-eligible in internal medicine) examined Claimant on April 3, 1980, and in his report, noted Claimant's reported symptoms of shortness of breath and CME of 20 years underground, as well as smoking history of ½ pack of cigarettes a day "for the past 8-9 years". Physical examination showed no clubbing, cyanosis or edema, and chest was clear to percussion and auscultation. A pulmonary function study revealed impaired function. The doctor diagnosed COPD of uncertain etiology, and occupational exposure to coal dust. The doctor testified at a state hearing that he did not believe Claimant has pneumoconiosis, and he found him capable of returning to CME.

Drs. Combs, Quillin, and Marshal interpreted X-ray evidence and rendered opinions accordingly. I shall consider their conclusions in accordance with section 718.202(a)(1) (see below).

Treatment Records

The record submitted with Claimant's previous claim contains documentation of his treatment at Pikeville Methodist Hospital in February, 1976 for a prepyloric ulcer and gastrointestinal hemorrhage secondary to the ulcer. He was treated again in August, 1979 for a fractured nose. DX-61. His treatment by Dr. Leslie is of record for the period from December 14, 1979 through October 11, 1993, and documents diagnoses for sinusitis, anxiety neurosis, acute bronchitis, and fractured ribs from a riding accident in April 1987. DX-62. The doctor noted moderate wheezing, ronchi, and congestion upon examination of Claimant. Id.

G. Elements of Entitlement

1. Presence of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202(a)(1) through (4):

A. X-ray evidence. § 718.202(a)(1).
B. Biopsy or autopsy evidence. § 718.202(a)(2).
C. Regulatory presumptions. § 718.202(a)(3).
    1. § 718.304 – Irrebuttable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.
    2. § 718.305 – Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner had proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.
    3. § 718.306 – Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971.
D. Physician's opinions based upon objective medical evidence. § 718.202(a)(4).

X-ray evidence, § 718.202(a)(1)

Under § 718.202(a)(1) the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with § 718.102. The current record has seven interpretations of two X-rays taken on September 18, 2001 and October 17, 2002.

It is well-established that the interpretation of an X-ray by a B-reader may be given additional weight by the fact-finder. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32, 34 (1985); *Martin v. Director, OWCP*, 6 B.L.R. 1-535, 537 (1983). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. *Scheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 131 (1984). In addition, the judge is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984); *Gleza v. Ohio Mining Co.*, 2 B.L.R. 1-436 (1979). Where X-ray evidence is in conflict, consideration shall be given to the expert's qualifications. *Dixon v. North Camp Coal Co.*, 8 BLR 1-344 (1985).

The evidence submitted with the subsequent claim includes new readings of two X-rays taken in 1980. Of the four readings of the February 21, 1980 X-ray, only the interpretation of Dr. Binns, a B-reader, was not negative. DX-35. The other negative readings were all given by B-readers, one of whom is also a board certified radiologist. I accord greatest weight to the dually qualified doctor, whose interpretation is supported by two B-readers, and find that this X-ray is negative for the presence of pneumoconiosis. All of the interpretations of the X-ray taken on April 3, 1980 were found to be negative by three B-readers, one of whom is also a board-certified radiologist. I find that this X-ray is negative.

Seven readings were conducted of the X-ray taken on October 15, 1986. Two doctors, one of unknown qualifications, and one B reader/board certified radiologist, found positive evidence of opacities consistent with the presence of pneumoconiosis. The other five doctors, all of whom are B-readers, read the film as negative. In addition, two of these doctors are board certified radiologists. I accord greatest weight to the two dually qualified doctors who read the film as negative.

The film of February 26, 1987 was read by three doctors, two of whom are B-readers, as negative. This evidence was uncontroverted, and I therefore find that this X-ray is negative for the presence of pneumoconiosis. There are six readings of the X-ray taken on April 6, 1987, all of which were read as negative. I therefore find that the record consistently establishes this X-ray as negative. Likewise, both readings of the X-ray of September 13, 1993 are negative.

The readings of the May 26, 1994 X-ray are in conflict, with one positive interpretation by a B-reader, and four negative interpretations, two of which are by B-readers and the others by physicians of unknown credentials. I accord more weight to the negative readings, as they are supported by two B-readers.

The X-ray of January 9, 1995 was read as positive by three highly qualified physicians, including a B-reader/BCR, a BCR, and an A reader.[5] One physician of unknown qualifications read the film as negative, and two other physicians found it unreadable. One B-reader/BCR interpreted the film as negative. I accord greater weight to the positive interpretations, because

[5] An "A" reader is also known as the first reader, and is a physician who has met the requirements established by NIOSH for certification.

of the superior qualifications of the physicians. Although the film was read as both positive and negative by a B-reader/BCR, the positive interpretation was supported by positive readings by a BCR and an A-reader, whose opinion is entitled to more weight.

The X-ray of November 20, 1995, was interpreted as negative by a B-reader, without conflicting opinion.

In summary, the evidence submitted with Claimant's subsequent claim reveals eight negative X-rays and one positive. An X-ray taken subsequent to the one interpreted as positive was interpreted as negative. I find that the X-ray evidence fails to establish the presence of pneumoconiosis.

The X-ray evidence considered in Claimant's original claim consists of readings of eight X-rays. Since the qualifications of the doctors who interpreted the X-rays of December 14, 1979 (Drs. Adams and Leslie) and January 11, 1980 (Dr. Penman) are unknown, I find them of little probative value.

Dr. Anderson (board certified radiologist, B reader) interpreted the January 18, 1980 X-ray as positive for pneumoconiosis, category 1. DX-42. This reading is uncontroverted, and in consideration of Dr. Anderson's credentials, I accord his opinion great weight.

Dr. G. N. Combs (board certified radiologist, B reader) testified at deposition on April 1, 1980, with respect to Claimant's claim for state benefits. The doctor found the X-ray evidence negative. DX-26. Dr. Allen L. Cornish (board certified in internal medicine) was deposed with respect to Claimant's state claim. He testified on July 3, 1980 that X-ray evidence did not show the presence of pneumoconiosis. DX-26. Dr. Ralph C. Quillen (board certified radiologist, B reader) was deposed on July 3, 1980, and testified that he found no evidence of pneumoconiosis on Claimant's X-ray. DX-26. Dr. T.R. Marshall (board certified in radiology, B-reader) testified at deposition on July 30, 1980, that X-ray showed no evidence of pneumoconiosis of pneumoconiosis. DX-26.

I accord great weight to Dr. Combs' negative reading of the February 11, 1980 X-ray because of his qualifications. With regard to the X-ray of February 21, 1980, I credit Dr. Cole's positive reading because of his credentials. I accord little weight to Dr. Wright's reading because his qualifications are not of record. The X-ray taken on April 3, 1980 was read as positive by a reader of unknown qualifications and as negative by a B-reader with board certification in radiology. Again, I accord greater weight to Dr. Cole's negative reading because of his superior credentials.

Since the reliable X-ray evidence establishes one positive X-ray and two negative, I find that the X-ray evidence of record in conjunction with Claimant's initial claim does not establish the existence of pneumoconiosis.

In the subsequent claim currently before me, additional readings of the February 21, 1980 and April 3, 1980 X-rays are of record. Of the four readings of the February 21, 1980 X-ray, none were conclusively positive, and all of the readings were performed by B-readers, one of

whom is also a BCR. The three additional interpretations of the April 3, 1980 X-ray were by B-readers, one of whom is also a BCR, and all were read as completely negative for pneumoconiosis.

I find that the X-ray evidence regarding these X-rays does not differ qualitatively from the evidence submitted in the initial claim. On the whole, the newly submitted X-ray evidence continues to fail to demonstrate the presence of pneumoconiosis. Considering all of the X-ray evidence together, Claimant has failed to establish a material change in condition through X-ray evidence.

Biopsy or autopsy evidence, § 718.202(a)(2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is unavailable here, because the current record contains no such evidence. This type of evidence is not of record in the initial claim, either, and accordingly, Claimant has failed to establish a material change in condition through biopsy.

Regulatory presumptions, § 718.202(a)(3)

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. § 718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physicians' opinions, § 718.202(a)(4)

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth as follows in subparagraph (a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance test, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical,' pneumoconiosis and statutory, or "legal", pneumoconiosis." Section 718.201(a)(1) and (2) define clinical pneumoconiosis and legal pneumoconiosis. Section 718.201(b) states:

> [A] disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

Subsequent claim medical opinion evidence

Dr. Williams based his opinion that Claimant has pneumoconiosis on his examination, his employment history, and an X-ray that the doctor found was positive. DX-9. Dr. Williams also concluded that Claimant had chronic obstructive pulmonary disease, and although he noted a smoking habit of ½ pack of cigarettes daily for 30 years, he did not explain how that habit would affect Claimant's condition. I have concluded that the X-ray at issue (October 15, 1996) was negative for the presence of pneumoconiosis, and without further foundation for Dr. William's opinion, I decline to accord it great weight as it is not well reasoned and is inconsistent with the objective evidence.

In 1993, Dr. Mettu found that Claimant had a pulmonary impairment that "could be related to occupational exposure". The doctor concluded that the objective tests showed the presence of obstructive airway disease, but allowed for the possibility of a component of restrictive disease. Dr. Mettu's documentation of Claimant's smoking habit was much less than what is recorded throughout the record, and he reached his opinion about the possibility of pneumoconiosis despite a negative X-ray. I decline to credit Dr. Mettu's opinion regarding the etiology of Claimant's pulmonary dysfunction because it is equivocal and not supported by the objective record. An unclear or equivocal opinion may be given less weight. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000).

Dr. Westerfield examined Claimant on May 26, 1994, and concluded that he had pneumoconiosis in reliance upon his positive reading of Claimant's X-ray of that date. The doctor also noted that blood gas study results showed mild oxygen desaturation on room air at rest. Although I recognize Dr. Westerfield's stellar credentials, I am unable to accord great weight to his opinion. Two other B readers interpreted the X-ray as negative, and I have credited their interpretation. The blood gas study results are not significantly abnormal, and are not at qualifying levels under the applicable regulations. Although Dr. Westerfield documents Claimant's 38 year history of smoking cigarettes, the doctor does not explain how this would not affect Claimant's test results. Accordingly, because Dr. Westerfield's determination is based upon objective evidence that I have discounted, and because he does not adequately explain his determinations, I conclude that his opinion is not well-documented or well reasoned. See, *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983).

Dr. Robert Cohen is a highly qualified physician whose review of the record also concluded that Claimant has pneumoconiosis. Dr. Cohen reviewed all of the objective evidence and all opinion evidence of record, and documented a smoking history of ½ pack per day for 21 years, with continued smoking of 2-3 cigarettes per day. The doctor noted the results of blood gas studies that showed abnormalities with gas exchange and observed that many X-rays were positive for the presence of pneumoconiosis. The doctor explained that the pulmonary function studies showed reductions in FEV1 that he could not attribute purely to cigarette smoking. The doctor found no other possibility for such reductions other than smoking and coal dust

inhalation. He found pneumoconiosis the more likely to cause of the abnormal test results because he compared Claimant's "15 to 20 years of significant exposure to coal dust" to "his very modest 5 to 15 pack year history of tobacco smoking". CX-3.

Dr. Cohen's trivialization of Claimant's smoking history undermines his opinion. Claimant's smoking history is not consistently reported, and ranges from the highest pack year of which was most frequently recorded as ½ pack of cigarettes per day, beginning in approximately 1970, with a reduction to 4 to 6 cigarettes per day starting in 1993, recorded by Drs. Fino, and Mettu (who recorded no previous smoking history). The smoking history was documented in the high range of ½ to 1 pack per day for since the age of 16 or 17, by Drs. Tutuer and Branscomb, respectively. At the hearing, Claimant testified that "when I started I couldn't tell you, but I smoked for quite a while…about half a pack." TR at 33. Claimant asserted that he cut back some time before, and was then smoking between two and four cigarettes daily, starting in 1994. Id. He said that he "chew[ed] a lot now". TR at 33.

Dr. Cohen's own summary of the evidence documented usage of ½ pack per day for 21 years, with continued use of 2 to 3 cigarettes daily. CX-1. This summary directly contradicts his stated consideration of "a modest 5 to 15 pack year". Id. I find the difference between 5 and 15 years significant, particularly where the doctor (as do all) relied upon 15 to 20 years exposure to coal dust as a comparison. I find that Dr. Cohen's discounting of Claimant's tobacco use seriously compromises his opinion, particularly where he had the opportunity to review all of the other physician's opinions and could not have failed to see how other doctors viewed the impact of smoking upon Claimant's pulmonary condition. Accordingly, I find that Dr. Cohen's opinion is not entitled to great weight.

Dr. Cohen's opinion is further discredited by his reliance upon evidence that is not entirely supported by the record. The doctor refers to many positive X-rays, and although I acknowledge that many of the X-ray readings were positive, my review of the evidence reveals that the X-ray evidence overall is negative for the presence of pneumoconiosis. Because Dr. Cohen also reviewed all of the X-ray evidence, his conclusions are less supportable than those of an expert who relied upon a single reading. I find that Dr. Cohen's opinion is not well reasoned and is not entitled to great weight.

Although Dr. Leslie was Claimant's treating physician, and his opinions deserve some deference due to that status, I find that they are not entitled to great weight because they are conclusory. Dr. Leslie's treatment notes refer to his diagnosis for pneumoconiosis, but they do not fully describe the extent of Claimant's treatment for the disorder. Dr. Leslie relied upon Claimant's exposure to coal dust, but makes little reference to the impact of his smoking habit upon his pulmonary condition.

Dr. Sundaram's conclusion that pneumoconiosis is present is entitled to weight. The doctor is board certified in internal and pulmonary medicine and is an A-reader, credentials that bear favorably upon his opinion. Dr. Sundaram recorded a smoking history of 3 cigarettes daily for 20 years, which is significantly less than what was consistently reported and noted. However, the doctor testified that his opinion would be unchanged in consideration of a smoking history of ½ pack per day for 26 years. The doctor explained that his findings are based upon the

objective test results as well as his examination. Dr. Sundaram's positive reading of an X-ray taken at his examination on January 9, 1995 was read as positive by a two board certified radiologists, one of whom is also a B reader. I find that Dr. Sundaram's opinion is well-reasoned.

Despite Dr. Sundaram's well-reasoned opinions, I find that the medical opinion evidence better supports a finding that Claimant has not established the presence of pneumoconiosis. I accord the most substantial weight to the opinion of Dr. Broudy, whose qualifications as a board-certified internist and pulmonologist are augmented by his status as a B-reader, and entitle his opinions to additional weight. I also find it significant that Dr. Broudy had the opportunity to examine Claimant, as well as to review all of the medical evidence of record. The doctor acknowledged Claimant's exposure to coal dust, but could not attribute his decrease in pulmonary function on tests in 1993 and 1995 to his CME, which ended in 1979. Rather, Dr. Broudy found it more consistent with his smoking history, which was documented consistent with the evidence on the whole. Dr. Broudy found that the abnormal blood test of 1993 reflected a temporary condition, because it was consistent with the decline demonstrated by the concomitant pulmonary function test. DX-67. I am persuaded by the doctor's well-reasoned and well-documented opinions.

Dr. Tuteur, whose credentials are outstanding, reviewed the entire medical record, and noted that the majority of the X-rays were negative for the disease. The doctor persuasively explained that the abnormal disclosures on objective testing were more typical for smoking-induced bronchitis than for pneumoconiosis. The doctor's record of Claimant's smoking history is consistent with the record as a whole, and he provides adequate support for his conclusion that the fluctuations in functioning demonstrated by objective tests was attributable to smoking, rather than to pneumoconiosis, which he maintained would produce persistent findings that are irreversible. The doctor provided an in-depth discussion of medical research into the interaction of smoking and coal dust-inhalation, and he provided the most persuasive explanation of the medical evidence of record. EX-16. I accord great weight to his opinion.

I accord significant weight to the opinions of Dr. Branscomb, who also found that the fluctuating values shown on objective tests showed that Claimant's pulmonary function was not attributable to pneumoconiosis. Dr. Branscomb's discussion of the entire record and his interpretation of the objective evidence are well-documented. The doctor reasonably describes how the test results of September 9, 1993 are inconsistent with pneumoconiosis, as the tests show an abrupt drop to severe reduction fourteen years after Claimant's last CME. DX-67. Although Dr. Branscomb is board certified in internal medicine, his credentials are inferior to those of Dr. Tuteur, whose opinions I credit with great weight.

Dr. Vuskovich conducted the most recent examination of record of Claimant on November 18, 1995, and found that Claimant did not establish the presence of pneumoconiosis. The doctor noted an occupational and smoking history consistent with the record as a whole, and objective tests that he administered produced abnormal findings. However, Dr. Vuskovich found no evidence of pneumoconiosis, and diagnosed chronic pulmonary disease secondary to cigarette smoking. EX-2, 13. Dr. Vuskovich's opinions regarding the existence of pneumoconiosis are not entitled to significant weight on their own because the doctor did not address the effect, if

any, of Claimant's significant coal dust inhalation upon his condition, but rather summarily concluded that pneumoconiosis would present as a restrictive impairment, not the obstructive impairment demonstrated by the objective testing.

Dr. Fino also reviewed all of the evidence of record and testified that it failed to show that Claimant has pneumoconiosis. Dr. Fino found that Claimant has a pulmonary impairment, but opined that the objective test results are compatible with diseases caused by cigarette smoking, and not with the permanent scarring and fibrosis associated with pneumoconiosis. Dr. Fino observed that Claimant continued to smoke after leaving CME, and objective test results showed defects that the doctor attributed to the continued smoking. Dr. Fino discounted pneumoconiosis as a diagnosis in part because of the obstructive nature of Claimant's respiratory dysfunction. I discredit that portion of Dr. Fino's opinion that concludes that pneumoconiosis would not exhibit findings of an obstructive disorder, but do not reject his opinion overall, as he explains that his conclusions are based upon the inconsistent nature of the objective tests, which he reasonably found would be contrary to the pattern expected for a progressive and irreversible disease such as pneumoconiosis.[6] I therefore accord some limited weight to Dr. Fino's opinion, particularly where it supports the conclusions of Dr. Tuteur and Dr. Broudy.

Dr. William Anderson, who is board certified in internal and pulmonary medicine, reviewed the evidence of record as of December 28, 1994, and concluded that it did not establish pneumoconiosis. The doctor noted the inconsistency of the objective findings and rejected them as typical for pneumoconiosis. Dr. Anderson concluded that Claimant's smoking would have caused his diminished pulmonary function regardless of exposure to coal dust inhalation. DX-67. Dr. Anderson did not render an unqualified opinion that Claimant does not have pneumoconiosis. Moreover, he had diagnosed the presence of pneumoconiosis in 1980, based upon his positive X-ray reading, and did not specifically retract that opinion. I find that Dr. Anderson's opinion is equivocal and entitled to little weight.

I find that the medical opinion evidence submitted with the current subsequent claim fails to establish the presence of pneumoconiosis. I now turn to the evidence submitted with Claimant's initial claim to determine whether it differs qualitatively from the newly submitted evidence. See, *Flynn*, supra.

Initial claim medical opinion evidence

Drs. Adams, Leslie and Penman, none of whose qualifications are of record, diagnosed Claimant with pneumoconiosis, based upon their examinations and X-rays. The X-rays that the doctors relied upon were not read by a doctor with special radiological credentials, and subsequent X-rays read by doctors with such qualifications were negative for pneumoconiosis. I

[6] Although the Board in its remand directed consideration of the effect of the holdings of Warth v. Southern Ohio Coal Co., 60 F.3d 173 (4th Cir. 1995) and Stiltner v. Island Creek Coal Co., 86 F.ed 337 (4th Cir. 1996). I find this unnecessary, because I do not accord weight to the medical opinions purely upon their consideration of whether pneumoconiosis may be demonstrated by tests showing an obstructive pulmonary impairment. Moreover, these opinions would be merely persuasive, as the instant case falls within the jurisdiction of the 6th Circuit Court of Appeals, and not the 4th Circuit Court of Appeals.

accord little weight to the opinions of these doctors, who acknowledged Claimant's smoking history, but declined to address how it would impact his pulmonary function.

Dr. Anderson (board-certified in internal and pulmonary medicine) concluded that Claimant had pneumoconiosis on the strength of his reading of an X-ray as positive. Since Dr. Anderson is a B reader, and in deference to his outstanding qualifications, I accord significant weight to his opinion.

Dr. Wright also diagnosed Claimant with pneumoconiosis in reliance upon his examination and a positive X-ray. Dr. Wright's qualifications are unknown, but the X-ray evidence that he relied upon was subsequently determined to be positive by a B-reader. Accordingly, I find that Dr. Wright's opinion is supported by the objective record and entitled to weight.

Dr. Cornish, who is board-certified in internal medicine, examined Claimant and also reviewed X-rays that were read by a BCR/B-reader as negative for pneumoconiosis. Dr. Cornish acknowledged Claimant's CME, and his smoking history, which he concluded was the cause of Claimant's chronic bronchitis. I accord more weight to Dr. Cornish's opinion because of his superior qualifications.

Dr. Sutherland examined Claimant and diagnosed COPD of uncertain etiology, and occupational exposure to coal dust. The doctor later testified that he did not believe that Claimant had pneumoconiosis. DX-42. I accord little weight to Dr. Sutherland's opinion because it is equivocal and inconsistent.

Although the opinions of Drs. Anderson and Wright appear to be well-documented, they are undermined by their reliance upon X-rays that I have determined to be negative, and their failure to fully discuss the impact of Claimant's smoking upon his condition. Moreover, their opinions are compromised by the X-ray evidence as a whole; the majority of subsequently-taken X-rays were interpreted as negative by highly qualified B-readers, whose opinions are entitled to more weight. Because Dr. Cornish reviewed all of the X-ray evidence of record, I find that his opinion is entitled to the most weight.

Accordingly, I find that the medical evidence submitted with Claimant's initial claim fails to establish the existence of pneumoconiosis.

Considering all of the evidence together pursuant to § 718.202(a), I find that the evidence does not establish the presence of pneumoconiosis. Therefore, Claimant has not established his entitlement to benefits under this element.

I further find that the evidence submitted with the subsequent claim does not differ qualitatively from the evidence submitted with Claimant's initial claim. I find that Claimant has failed to establish a material change in conditions with respect to this element of entitlement.

2. Pneumoconiosis Due to CME

As Claimant has not established the presence of pneumoconiosis, there is no need to examine this causation element.

3. Total Disability

Assuming *arguendo* that Claimant had established the existence of pneumoconiosis, Claimant must then establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) provides as follows:

> [A] miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner:
>
> (i) From performing his or her usual coal mine work; and (ii) From engaging in gainful employment … in a mine or mines …

§ 718.204(b)(1).

Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. § 718.204(a).

Claimant may establish total disability in one of four ways: PFTs; ABGs; evidence of cor pulmonale with right-sided congestive heart failure; or reasoned medical opinions. 20 C.F.R. § 718.204(b)(2)(i-iv). Producing evidence under one of these four ways will create a presumption of total disability only in the absence of contrary evidence of greater weight. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987).

Pulmonary function studies

In order to establish total disability through PFTs, the FEV1 must be equal to or less than the values listed in Table B1 of Appendix B to this part and, in addition, that test must also reveal either: (1) values equal to or less than those listed in Table B3 for the FVC test, or (2) values equal to or less than those listed in Table B5 for the MVV test or, (3) a percentage of 55 or less when the results of the FEV_1 test are divided by the results of the FVC tests. § 718.204(b)(2)(i)(A-C). Such studies are designated as "qualifying" under the regulations. Assessment of PFT results are dependent on Claimant's height, which was noted variably throughout the record. I must resolve the height discrepancy, and because it is the most frequently measured height, I have used 65 inches when evaluating the pulmonary function study evidence. *Protopappas v. Director*, 6 B.L.R. 1-221 (1983).

Newly submitted pulmonary function evidence

The January 18, 1980 study did not produce qualifying results. Drs. Cohen and Branscomb reviewed the results of this test and concluded that they reflected inadequate effort on Claimant's behalf. Drs. Cohen and Fino reviewed the non-qualifying results of the February 17, 1980 study and also found them valid. Both Drs. Cohen and Fino are board certified in pulmonary medicine, and Dr. Branscomb is a board-certified internist. I accord great weight to their determinations.

Drs. Cohen and Fino reviewed the April 3, 1980 study. Dr. Cohen found that the tracings were not legible. Dr. Fino, whose credentials are equivalent to Dr. Cohen's, validated the test. I find that the evidence regarding this test is in equipoise, and conclude that the evidence regarding this study has no probative value.

Drs. Fino and Cohen reviewed the non-qualifying study of October 15, 1986 and found it valid. Dr. Williams, who authorized the test, also concluded that the results were valid. I find this non-qualifying test valid.

Four doctors (Branscomb, Cohen, Fino and Dahhan) concluded that the results of the February 26, 1987 non-qualifying test were valid. I find that the test is valid. Drs. Broudy, Fino and Cohen validated the non-qualifying study of April 6, 1987, and I find that the test is valid.

The study of September 9, 1993 was validated as qualifying by Drs. Mettu, Kraman, and Broudy. Drs. Fino and Broudy found that the test was not valid. Dr. Branscomb found that the variable results between the three efforts were in excess of the variation permitted under the regulations. The doctor also concluded that it was inappropriate to obtain three expiratory efforts because the first two were not reproducible. Dr. Fino also concluded that the test was invalid in part because of the lack of reproducibility in the tracings. Dr. Fino also found that the tracings revealed problems with Claimant exhalation.

I accord greater weight to the conclusions of Drs. Branscomb and Fino because they are well-reasoned. I also attribute some weight to their credentials: both doctors are board certified in internal medicine, and Dr. Fino is also board certified in pulmonary medicine. Moreover, I find the results suspect because the pulmonary function tests administered subsequent to this test produced higher results. It is generally accepted that while spuriously low values are possible, spuriously high values are not. See, *Andruscavage v. Director, OWCP*, No. 93-3291, slip op. at 9-10 (3rd Cir., February 22, 1994)("medical literature supports…the conclusion that [pulmonary function studies] which return disparately higher values tend to be more reliable indicators of an individual's respiratory capacity than those with lower values"). Consequently, I find that the study of September 9, 1995 is not valid.

I accept that the results of tests performed in 1993, 1994 and 1995, reflect a decline in Claimant's pulmonary function from the earlier conducted studies, the last of which was performed on April 6, 1987. The test of May 26, 1994 produced qualifying results, and was validated by two highly qualified physicians. The test of January 9, 1995 also produced qualifying results. Dr. Branscomb rejected the results as non-conforming, but Dr. Cohen and Dr.

Sundaram both found the results valid, and I accord greater weight to their opinions. However, the test performed on November 18, 1995 produced non-qualifying results and was validated by two physicians, Drs. Cohen and Vuskovich. I credit their determination and find the test valid. I accord significant weight to this most recently conducted study as well.

Although the pulmonary function study evidence demonstrates that at times Claimant's pulmonary function was deficient at qualifying levels, the overall evidence does not establish by test results alone that Claimant is disabled. The November 18, 1995 test also produced higher values than those produced in the May 26, 1994 and January 9, 1995 tests, which in turn were greater than the test results of the September 9, 1993 study. I also note that the February 26, 1987 and April 6, 1987 tests produced higher results than the earlier test of October 15, 1986. That test produced higher results than two of the 1980 tests, April 3, and February 17, 1980. Although doctors were able to validate individual tests results, the fluctuation of those results renders the pulmonary function study evidence unreliable. I find that the newly submitted pulmonary function evidence does not establish Claimant's total disability.

Pulmonary function study evidence submitted with initial claim

The pulmonary function tests of January 18, 1980, February 27, 1980, and April 3, 1980, produced non-qualifying results and were deemed to be valid. These tests were medically reviewed in conjunction with Claimant's subsequent claim, and again determined to represent valid, non-qualifying results. I find that this evidence does not differ qualitatively. However, as I have noted, the more recent pulmonary function study evidence reflects a decrease in function since 1980 with some tests falling within qualifying ranges of dysfunction. Consequently, the evidence overall differs from that submitted with Claimant's initial claim. I have concluded that the test results are not a reliable indicator of disability, as they vary unpredictably, with later tests producing higher results than earlier ones. Accordingly, I find that Claimant has been unable to establish a material change in condition on the basis of pulmonary function studies alone.

Considering all of the pulmonary function test evidence together, I find that it does not support a finding that Claimant is totally disabled under § 718.204(b)(2)(i).

Arterial Blood Gas Studies

Although the arterial blood gas studies did not yield qualifying results, reviewing doctors noted variable mild hypoxemia. The blood gas studies submitted with Claimant's subsequent claim do not differ qualitatively from that submitted with his initial claim, for purposes of finding a material change in condition; in fact, some of the later studies produced better values than the earlier studies. The arterial blood gas evidence, therefore, does not support a finding that Claimant is totally disabled under the provisions of § 718.204(b)(2)(ii), nor does it demonstrate a material change in condition.

Cor Pulmonale

Under § 718.204(b)(2)(iii), total disability can also be established where the miner had pneumoconiosis and the medical evidence shows that he suffers from cor pulmonale with right-

sided congestive heart failure. There is no record evidence of cor pulmonale with right-sided congestive heart failure.

Medical Opinion

The remaining means of establishing total disability is with the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. 20 C.F.R. § 718.204(b)(2)(iv).

Subsequent claim medical opinion evidence

Although all physicians of record agree that Claimant has a pulmonary impairment, the opinions are divided regarding Claimant's ability to resume his former CME or similar manual labor. Dr. Williams concluded that he could not. This opinion is inconsistent with his finding that Claimant has moderate pulmonary impairment. Moreover, Claimant's valid pulmonary function test associated with Dr. William's examination did not produce qualifying results. I find that his opinion is not well-reasoned and not entitled to great weight.

Dr. Mettu's opinion is founded upon a pulmonary function test that he found showed severe pulmonary impairment. I have determined this test to be invalid, and consequently find that Dr. Mettu's opinion is not well-reasoned or well documented. I accord it little weight.

Dr. Westerfield found that pulmonary function study results revealed that Claimant had a moderate obstruction dysfunction that improved significantly after administration of bronchodilator. The doctor determined that Claimant would be unable to return to CME. I find that this opinion is conclusory and inconsistent, and not entitled to great weight, despite Dr. Westerfield's exemplary credentials.

Dr. Sundaram's qualifications are also outstanding, but his opinion that Claimant is disabled is undermined by his conclusion that pneumoconiosis is responsible for his pulmonary dysfunction. The doctor specifically discounted Claimant's smoking habit in reaching his conclusions. I find that Dr. Sundaram's opinion is not well reasoned or well documented, and consequently, accord it little weight.

Dr. Vuskovich concluded that Claimant would have difficulty performing heavy manual labor, but could work as a scoop operator. Moreover, the doctor found that Claimant's condition would improve if he stopped smoking and underwent therapy. I cannot credit Dr. Vuskovich's opinion because I find it equivocal and inconsistent.

Dr. Leslie, Claimant's treating physician, concluded that he has a disabling respiratory impairment that prevents him from returning to his CME. However, the doctor did not specify the extent of Claimant's impairment or how it impacted his ability to engage in activity. Treatment records are in evidence, but they provided no further clarification of the basis for the doctor's opinion. I therefore find it conclusory and entitled to little weight.

Dr. Cohen reviewed the entire medical record and concluded that Claimant had a pulmonary impairment that was evident from his symptoms and objective tests. The doctor found that Claimant's smoking and pneumoconiosis contributed to his condition, and provided a reasonable explanation of how pneumoconiosis could cause an obstructive pulmonary defect. The doctor pointed to abnormal gas exchanges and several pulmonary function tests that showed dysfunction. Although Dr. Cohen is a highly qualified physician, and has made reasonable arguments in support of his opinion, I find that it is founded on some erroneous information. First, the doctor specifically relied upon a history of fewer pack years than are supported by the record. Also, Dr. Cohen stated that Claimant's pulmonary function showed no significant improvement after bronchodilators, which is not entirely consistent with the record. Moreover, he failed to explain why pulmonary function tests varied so radically or why some tests showed improved results when compared with tests performed earlier. Despite the thoroughness of the doctor's reports and testimony, and his excellent credentials, I must give little weight to his opinion on Claimant's disability because it is not fully reasoned or well-documented.

Dr. Dahhan's opinion regarding Claimant's ability to work varied in relation to the results of pulmonary function tests. In his earlier reports, the doctor concluded that Claimant would be able to return to his work in mining. In his most recent report, the doctor observed that Claimant's recent pulmonary function tests demonstrated that he would be unable to perform hard labor. I must discount Dr. Dahhan's opinion because it is not completely consistent with the evidence. The doctor's most recent report was prepared on December 27, 1995, a full month after the last pulmonary function study of record was conducted on November 18, 1995. That test produced valid, non-qualifying results, which Dr. Dahhan did not address. Moreover, the results of that test showed improvement over the three previously conducted tests. I find that Dr. Dahhan's opinion is undermined by this oversight, and it therefore is entitled to little weight.

Likewise, Dr. Broudy's testimony regarding Claimant's ability to return to CME was based upon the results of the pulmonary function tests of record. The doctor stated that FEV1 results of 70% would be sufficient to allow Claimant to work. However, the doctor gave no definitive opinion regarding what he believed the results to actually represent. The doctor's opinion is not reliable because is not completely consistent with the evidence. Dr. Broudy did not offer an explanation for the fluctuation in test results. Moreover, he stated that Claimant's lung function had progressively deteriorated since 1987, yet the tests showed deterioration, followed by improvement, followed by deterioration, followed by improvement. He relied as well upon a study that I have determined is invalid. I find that Dr. Broudy's opinion is not well-documented or well reasoned, and therefore, not entitled to great weight.

I accord greater weight to the opinions of record that conclude that Claimant was not totally disabled by a pulmonary impairment. I accord greatest weight to Dr. Branscomb's conclusion that Claimant has a condition that affects him in a temporary way, as demonstrated by the fluctuation of pulmonary function tests. This opinion is supported by the objective record, which showed fluctuation in test results and not a continuous decline. Pulmonary function studies conducted in November 1995 produced higher results from earlier studies. Coincidentally, at his most recent examinations, including the one that precipitated the November study, Claimant reported a significant reduction in the number of cigarettes he

smoked, from ½ pack per day to as few as 2 or three. The increased function demonstrated in the objective tests is consistent with Dr. Branscomb's opinion. I credit Dr. Branscomb with additional weight because he is board certified in internal medicine.

Dr. Anderson also attributed Claimant's reduction in pulmonary function to a variable defect that was compatible with smoking. The doctor concluded that Claimant's level of impairment would permit him to perform his CME. Dr. Fino also reasonably concluded that Claimant's impairment showed reversibility, and found that his loss of function was slight. Dr. Tuteur agreed that Claimant had some impairment of function but did not find it totally disabling. All of these physicians are board certified in internal and pulmonary medicine, and their opinions are accorded additional weight on the strength of those qualifications.

In light of the above, the physicians' opinion evidence does not support a finding that Claimant is totally disabled, pursuant to § 718.204(b)(2)(iv).

Initial claim physician opinion evidence

Dr. Adams examined Claimant in 1979 and found evidence of pulmonary disease. The doctor recommended that Claimant avoid further exposure to dust, but his opinion regarding Claimant's ability to perform similar work is not definite. Dr. Penman rendered a diagnosis and concluded that Claimant's "lung function is impaired" (DX-42), but did not offer a definite opinion regarding disability. Similarly, Dr. Anderson examined Claimant but declined to render an opinion regarding Claimant's level of impairment or ability to work. Dr. Cornish testified about his examination findings, but also did not make an assessment of Claimant's ability to work. Therefore, I find their opinions of little probative value to my determination of this issue, and consequently I accord them little weight.

Dr. Leslie examined Claimant in 1979 and concluded that he was disabled from his CME and any other strenuous labor. I find little objective evidence to support this conclusory opinion, and I therefore accord it little weight.

Dr. Wright also concluded that Claimant should not be exposed to coal dust, finding that he had moderate obstructive airway defect and was unfit for CME. The objective evidence is not consistent with the doctor's conclusion and I therefore discount Dr. Wright's opinion.

Dr. Sutherland testified that Claimant had some pulmonary impairment, but concluded that he could return to CME. The doctor based his opinion upon his examinations of Claimant and his review of the objective evidence. I find the doctor's opinion to be well supported by the record and well-reasoned and entitled to substantial weight. Dr. Sutherland's credentials as eligible for board certification in internal medicine entitle his opinion to some added weight. Therefore, I accord greatest weight to Dr. Sutherland's opinion.

In summary, the physician opinion evidence submitted with his initial claim does not establish that Claimant is totally disabled. This evidence does not differ qualitatively from that submitted with his subsequent claim. I find that Claimant has failed to establish a material change in condition pursuant to § 725.309(d).

Weighing all the medical evidence, Claimant has failed to establish total disability under the provision of § 718.204(b)(2)(i-iv), or a material change in conditions.

4. Total Disability Due to Pneumoconiosis

Since Claimant has not proven total disability, there is no need to resolve the causation issue.

H. Conclusion

As Claimant has failed to establish all the requisite elements of entitlement and has not established a material change in conditions, his claim for benefits under the Act must be denied.

ATTORNEY'S FEE

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging if any fee to Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of RAY CASE for benefits under the Act is DENIED.

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JANICE K. BULLARD
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with the Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this Notice must be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.